July 1998 Issue | Sherry A. Rogers, M.D., P.C.

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Welcome to *Functional Medicine Update*™ for July, 1998. We have been discussing the cost/benefit (to the patient and to the economic system) of healthcare delivery from a functional medicine perspective. We define functional medicine as the field of health care that focuses on assessment and early intervention into the improvement of physiological, cognitive, emotional, and physical functioning. That definition moves us beyond the differential diagnosis model, the histopathology model of disease.

From a functional medicine perspective, we examine outcome-based studies to see the relationship between multivariate interventions and multivariate outcomes in patients. We want to determine if the functional medicine approach is both more cost-effective and more beneficial to patients in terms of long-term improvements in functional ability. These two may be more appropriate considerations for decision making.

In evaluating outcomes from a functional medicine viewpoint, we also need to consider multiple variables. Our viewpoint should not be limited by the double-blind, placebo-controlled outcome trial that evaluates the effectiveness of a single agent against a single variable. Although this method is useful in evaluating studies in which a single agent is used to remedy a single problem, most chronically ill patients as they grow older suffer from a variety of symptoms. Those symptoms are not easily understood as histopathology-based, single outcome entities. Nor can they generally be treated by a single remedy. The double-blind, placebo-controlled trial thus becomes less valuable in these circumstances than methodologies that evaluate a number of variables.

A recent issue of the *Journal of the American Medical Association* contained a paper titled "Evidence-based Disease Management."[1] "Evidence-based" is a current buzzword related to outcome analysis. It suggests that the scientific medicine we have supposedly been practicing for the last couple of decades was not evidence-based.

Evidence really refers to "where the tire meets the road." How is the patient responding? What is the quality of the outcome as perceived by the patient? As perceived by the practitioner? As perceived by the patient's support group – family and friends? In other words, it means looking at evidence as an empirical series of observations, not solely tied to a laboratory parameter or a single entity of evaluation.

In this *JAMA* paper, the authors looked at the diabetic patient and the long-term management and outcome basis for proper management of diabetes. They examined the evidence-based criteria for

effective outcome. They state,

> "Disease management is an approach to patient care that emphasizes coordinated, comprehensive care along the continuum of disease and across healthcare delivery systems. Evidence-based medicine is an approach to practice and teaching that integrates pathophysiological rationale, caregiver experience, and patient preferences with valid and current clinical research evidence."

That language closely resembles the objectives of functional medicine. In this paper, the authors present a method for developing and implementing clinical outcome guidelines, to drive improvements in quality and cost effectiveness of diabetes care. The authors emphasize the importance of multidisciplinary teams of medical professionals and paraprofessionals working together to develop and implement an evidence-based disease management program focused on diabetes. They feel this program is essential in the prevention, diagnosis, and therapeutic decisions made to improve long-term patient care, outcome, and function

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INTERVIEW TRANSCRIPT

Clinician of the Month:

Sherry A. Rogers, M.D., P.C.

JB: This month, we are fortunate to visit with a colleague and professional guide, Dr. Sherry Rogers. This is Dr. Rogers's third appearance as *FMU* Clinician of the Month. Dr. Rogers is a medical doctor who did her internship at SUNY Upstate Medical College at Syracuse. She is a board-certified family practitioner and has also worked in environmental medicine. She is a Fellow of the American College of Allergy and Immunology. She had a private practice in pediatrics, worked in emergency room medicine, and, for the last 26 years, has maintained a private practice in environmental medicine. She is a resource for patients and practitioners all over the world who attend her lectures and read her many books and articles. Dr. Rogers has blended her clinical acumen with scholarship, research, and teaching to advance the field. Together with Dr. Bill Rea, she represents for most of us the forefront of our understanding of environmental medicine. Dr. Rogers has worked and written about a wide range of disciplines. That work serves as educational material for practitioners and appears in numerous books she has published for the general public. Two of her current books are *Depression Cured at Last* and *Wellness against All Odds.*

JB: Sherry, please tell us how you made the transition from standard practice and emergency room medicine to complementary medicine some 20 years ago.

SR: I got into complementary medicine the same way a lot of other people did. I was so sick, I had no choice. In the 1960s, doctors could have free services – consultations with physicians, medicine, tests – and I took advantage of those free services. Frankly, no one knew what was wrong with me. I kept getting sicker and sicker and had over 20 different diagnoses.

I was led into environmental medicine because there wasn't anything else left to do. I got better by leaps and bounds, and now, at age 55 I am healthier than I've ever been in my life. I play four hours of tennis a day and have lots of energy left over to do this fascinating and incredible research. I feel really lucky and blessed. I spent years saying "why me?" and "poor me," and going through everything from filling the toilet bowel with blood 12 times a day between patients, to brain fog and depression, asthma, eczema, chronic sinus problems, migraines, chronic fatigue, and fibromyalgia. I even broke my back six times. All of that is totally gone. I'm so grateful. I spend my waking hours trying to pull together all of the research that explains why and how, so doctors around the world can continue with this work. You have done a marvelous job, Jeff, in educating all of us, and have had a major role in this transformation.

JB: In your recent book, *Depression Cured at Last*, a first-class, scholarly, 700-page book containing more than 1000 references, you discuss environmental influences on brain chemistry. Alterations in brain chemistry can lead to depression, which the medical world has treated as a symptom for which the treatment is a mood-altering drug that produces chemical incarceration. You have been successful in implementing alternatives that deal with the cause, not just with the symptom of depression. How did you begin to make the clinical connections between what might be considered the field of psychiatry and aspects of environment that patients can control?

SR: A lot came first from personal experience. I had tremendous brain fog, and I have an IQ over 156. I couldn't think my way out of a paper bag sometimes. I was horribly depressed, although I had not a thing to be depressed about. I worked with Bill Rea in the beginning. I tested foods with Joe Miller. I went all over the place and did everything and anything I could possibly do. I started attracting the attention of people from all over the country with the same problems. We spent night and day trying to figure out the causes. It's been extremely interesting.

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